

## POG II: TOLLGATE 1 - Maximize the Health of Washingtonians

### 1. Identify key indicators.

POG I indicators were: 1) Epidemiological (population-based) measures, 2) Individual self-assessment of health, and 3) Access

POG II recommended indicators:

Indicators	Same/ Modified/New	Remarks
<b>1) Epidemiological (population- based) measures</b> <ul style="list-style-type: none"><li>• Rate of tobacco use</li><li>• Rate of increase in levels of obesity</li></ul>	Modified  New  New	Simplification of an assortment of measures, focusing on the two major leading causes of death – shown below.  Tobacco use accounted for 18.1% of deaths in the US in the year 2000  Inactivity / poor nutrition accounted for 16.6% of deaths in the US in 2000. The next greatest cause of death (alcohol) caused 3.5%.
<b>2) General health</b> <ul style="list-style-type: none"><li>• Average years of healthy life remaining at 20</li><li>• Infant mortality</li></ul>	Modified New  New	A composite of age-specific mortality rates from the vital statistics data and age-specific self-reported health status captured by the Behavioral Risk Factor Surveillance System (BRFSS).  "Years of healthy life" does not capture the 0 to 20-year age range. Infant mortality is the proxy for measuring overall health from 0-20.
<b>3) Access</b> <ul style="list-style-type: none"><li>• Insurance coverage</li><li>• Unmet healthcare need</li></ul>	Modified Modified  New	Refines the measure of "access" to include coverage by age group (child, adult, senior), as well as total coverage.  "Insurance coverage" (above) is not a full measure of access since some individuals without coverage might access health care through clinics and some individuals with coverage might have difficulty finding willing providers. This indicator, then, supplements the measure of access and is derived from responses to questions in the BRFSS.

### 2. Update the causal (strategy) map.

Attachment A.

### 3. Provide initial assessment of success or failure of current strategies.

**Does the current budget include funding for all of the significant strategies identified by the teams last time? Which strategies were not funded in the budget?**

The group's significant strategies were largely followed throughout the budget process and in the final, enacted budget. Although, in a budget period with a \$2.6 billion shortfall, the full mapped strategy was not funded, policymakers largely conformed to the Health Results Team priorities.

The Team's purchase plan addressed the major strategies by prioritizing spending as follows: The Team saw population-based interventions as providing the largest return on investment (ROI) and representing the first area of public sector responsibility. Population-based investments were seen to contribute to three of the four major strategies – increasing healthy behaviors through education and outreach, mitigation of environmental hazards, and identifying and mitigating risk factors. The Team recommended continuation of existing funding plus additional investment in this area.

The Team's purchase plan addressed the provision of access to healthcare by prioritizing populations receiving direct state coverage from most- to least-vulnerable. In addition to coverage for groups characterized as "most vulnerable," the Team provided targeted investments in the baseline safety net through increased grants to community clinics.

The groups not funded in the purchase plan, given the Team's funding allocation, included: childless adults in the Basic Health (BH) program; children over 200 percent of the federal poverty level (FPL); and approximately 200 workers with disabilities with incomes up to 450 percent of FPL. Neither did the Team's purchase plan include funding for dental, vision, and hearing services for Medicaid adults or the Medically Indigent (MI) program that reimbursed providers for uncompensated emergent medical care.

The Governor's budget proposal closely mirrored the Team's purchase plan with the following exceptions. Existing levels of funding for public health were maintained but the enhanced investments in this area were not funded (with the exception of relatively small enhancements to newborn testing and some improvements to the food code). The Governor conformed to the Team's prioritization of coverage to vulnerable groups although he continued coverage for children between 200 and 250 percent FPL. The Governor also funded enhancements to the safety net via increased grants to community clinics.

After release of his original proposal, the Governor directed the Health Care Authority to reduce the size of the BH benefit package and increase enrollees' cost sharing – enabling more people to retain some BH coverage. He also directed the department to freeze enrollment, allowing the greatest possible reductions to occur through natural attrition rather than forced disenrollment.

The enacted budget corresponded to the Governor's refined proposal with the following exceptions. The complete elimination of adult dental, vision, and hearing services was replaced by a 25 percent reduction in dental services, and co-pays for vision and certain medical equipment. The enhancements to community clinic grants were not included.

The activities the Team did not purchase in its own plan but *were* purchased by policy makers included: additional enrollment slots in the BH plan by reducing the benefit package, the State Children's Health Insurance Program (SCHIP) for children over 200 percent FPL, healthcare for workers with disabilities, three-fourths of dental services for adults and continued vision and hearing care for adults. In addition, the Legislature added hospital grant funds to compensate for the loss of the MI program.

**Looking at the performance and indicator information available to you at this time, how would you describe progress in achieving this result?**

The overall strategy of the Team, constrained by available funding, was accepted by policymakers and funded in the 2003-05 biennial budget. Except for insurance coverage, not enough time has elapsed to measure most specific effects of the enacted plan. The enacted plan did not fully fund the ideal strategy designed by the Team but prioritized activities that remained after deep budget cuts.

**What are the most significant areas of success in this result area today?**

Funding of preventative interventions continues to yield results. Examples of funded, high-priority, population-based activities that have, in fact, produced improvements:

1. Tobacco use causes heart and lung disease, cancer, and strokes. Washington state has a comprehensive tobacco prevention strategy that's resulted in declining tobacco use among

youth and adults. About 53,000 fewer Washington children are smoking now than before the state's investment in tobacco prevention; the rate of decline is greater than the national average. The decline in 10th grade smokers from 1999-2002 was 40%; 12th grade was 36%. The data were collected through the Health Youth survey of nearly 140,000 students in 752 Washington schools statewide in October 2002. There are about 83,000 fewer adult smokers in Washington – an 8% decrease (1999-2002).

2. There is strong statistical evidence that state funded services to low-income pregnant women have had a favorable impact on infant mortality and will have an impact on the future health of the children born to low-income women. Infant mortality rates (IMR) in Washington state are lower than the national average. From 1990 to 2001, the IMR for Medicaid infants decreased by 50 percent -- from 11.1 per 1,000 in 1990 to 5.6 per 1,000 in 2001. In the same time period, the IMR for non-Medicaid infants decreased by 28 percent -- from 5.6 per 1,000 to 4.0 per 1,000 in 2001. The IMR improvements are likely attributable to three main factors: declining Sudden Infant Death Syndrome, addressed by the "Back to Sleep" campaign; improved survival of very premature infants, who are small in number; and the First Steps program. The Maternity Care Access Act of 1989 authorized the First Steps Program -- a collaborative effort between DSHS and the Department of Health -- to increase access to prenatal care, expand Medicaid services for low-income women, and remove unnecessary barriers to receipt of prenatal care. Access to prenatal care for Washington women clearly improved after the First Steps program began.

Other measures of improved infant and childhood health include the rate of low birthweight babies. Improved birth weights suggest these infants will have lower risk of health problems associated with low birth weight and will incur lower medical care costs during infancy and early childhood. Women newly eligible for Medicaid through First Steps' expanded eligibility experienced the greatest decrease in low birth weight, from 5.8 percent before First Steps (1988-89) to 3.9 percent in 1993-94. This represents a 33 percent decrease in low birth weight for this group. In addition, low birth weight decreased for all women statewide and for poor women on the AFDC program.

3. 4,000 public water systems serve over 5 million people in the state. The goal was to have 85% or more of these systems in compliance with coliform monitoring requirements. In 2003-2004, more than 90% of the water systems complied with this measure.

4. Enactment of the primary seat belt law increased belt use from 83% to 95%. Eighty-four lives were saved from June 2002 through July 2003.

5. State government's continuing commitment to provide subsidized coverage for low- and moderate-income children has resulted in Washington having one of the lowest children's uninsured rates in the country.

**Where do you see the most significant performance gaps? Do these gaps represent the failure of a strategy, the failure to fund a given strategy, or something else? Where are the most significant opportunities to improve results?**

The access portion of the Health Result area was not fully funded. Indicators other than population-based indicators are either inconclusive or it is too soon to measure impacts. The Washington State Population Survey, which is currently in the field, will yield results by September 2004 that will provide health insurance coverage data. We expect to see decreases in health care coverage for both children and adults—in part due to changes in

eligibility requirements for children, reductions in BH coverage, and further erosion of employer-sponsored coverage.

### ***Public Health Services***

The requested increase was not funded. Local government public health agencies are the “front line” in protecting and improving health. Services typically include, communicable disease response, safe food and drinking water, support for healthy children and families, promoting healthy behaviors (e. g. reduced tobacco use, better nutrition), referral to medical care and coordination of local health resources. With growing pressure on county budgets, local service capacity is jeopardized by insufficient and unstable funding.

### ***Physical Activity and Nutrition (reducing overweight and obesity)***

Inactivity and poor nutrition rank second only to tobacco use in cause of death in the U.S. 59% of adults in Washington State are overweight or obese. 21% of Washington state high school students are overweight or at risk of becoming overweight. The obesity rate among adults in Washington state increased by 127% from 1990 to 2002. At current rates, we can hope to only slow the growth of obesity, not turn it around. Because overweight and obese individuals are at increased risk for physical ailments such as: high blood cholesterol, type 2 diabetes, insulin resistance, coronary heart disease, stroke, gout, osteoarthritis, obstructive sleep apnea and respiratory problems, and some types of cancer, it is imperative that we take a population-based, “tobacco-like” approach to this issue.

### ***Zoonotic (Animal-Borne Disease)***

In recent years, nearly all emerging diseases have been linked to zoonotic sources. We expect significant impact from West Nile Virus in 2004. About half the requested funding was provided this year, but demand may likely outstrip these resources.

### ***Food Safety***

Food contamination continues to be a significant source of human health problems. About half of requested resources were provided last year. Full funding would provide attention to food agr-terrorism, fish advisories, and assuring consistency among local agencies.

### ***Emergency Room Use***

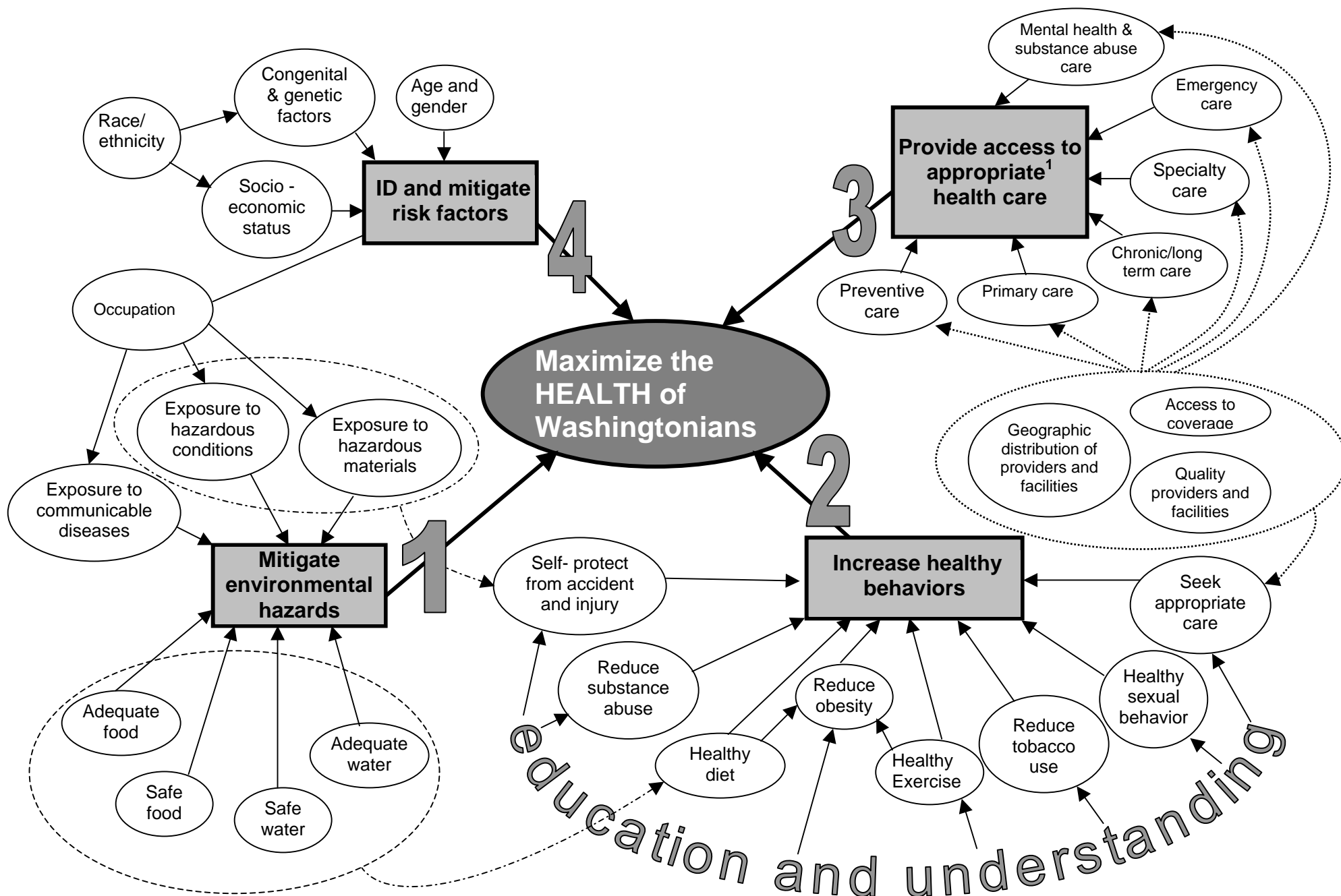
There is an opportunity to reduce hospital Emergency Room misuse through a) improving use of clinics during clinic hours, b) encouraging providers to serve clients in the appropriate setting, c) ensuring an adequate supply of physicians across the state, and d) improving funding of preventive and appropriate care—such as mental health and substance abuse care.

Data gaps inhibit full measurement of inappropriate use of health care resources. Our statewide data collected from hospitals are currently constrained to inpatient care – which does not capture emergency room use. Since major shifts are occurring in place of service delivery from inpatient to other sites, the state should add outpatient care data to routinely collected inpatient hospital data.

### ***Injury Prevention***

Injuries are the leading cause of death for people age 1 – 44 in Washington state, and remain a high cost, high incidence issue throughout the life span. High-risk groups include children, young adults, seniors and low-income populations. There are proven population-based interventions available to reduce injuries in high-risk populations; however, there has never been significant funding identified to address injury prevention. For example, one model program reduced falls among older adults by 30%. Falls among seniors account for more hospitalizations than all motor vehicle crashes – and two thirds of the seniors who fall are discharged to nursing homes.

**Attachment A – Causal (Strategy) Map ~ Maximize the Health of Washingtonians**



<sup>1</sup> “Appropriate” means evidence-based, quality, and cost-beneficial care when applied to the design, treatment and delivery of health services.